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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0009	A. BUILDING _____ B. WING _____	06/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 02	1226 LAWRENCE STREET, NE WASHINGTON, DC 20017

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I 000	INITIAL COMMENTS A licensure survey was conducted from June 9, 2009 through June 12, 2009. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a resident population of seven males with various disabilities. The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at three day programs, as well as a review of client and administrative records, including incident and investigation reports.	I 000	Received 7/3/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on observations and interview, the GHRMP failed to ensure that each staff prepared food in sanitary conditions at all times for seven of seven residents residing in the GHRMP. (Clients #1, #2, #3, #4, #5, #6, and #7) The finding includes: On June 10, 2009, at 3:14 PM, a pack of chicken was observed thawing out inside the kitchen sink with warm water running over it. The Qualified Mental Retardation Professional (QMRP) was made aware this issue an immediately turned the water from warm to cold while the chicken continued to be thawed out inside the sink. The QMRP acknowledged that staff should have ran	I 058	See W454	

Health Regulation Administration

Michelle Thomas — V. Sands — 6/30/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 056	Continued From page 1 cold water over the chicken. There was no evidence that the GHMRP maintained a sanitary environment to avoid sources and transmission of infection.	I 056		
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the GHMRP failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, attractive, and sanitary manner. The findings include: Observation and interview with the House Manager during the environmental walk through on June 12, 2009, beginning at 12:22 PM, revealed the following. 1. The front left and rear eyes located on the kitchen stove was observed to be inoperable. Interview with the House Manager revealed that they purchased a new stove the day before the surveyors arrived. 2. The handrail leading from the main hall way to the basement was observed to loose. 3. The back door screen was observed to be torn.	I 091	New stove delivered on 6/13/09 Rail has been tightened Screen has been replaced	6/13/09 6/13/09 6/12/09

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I 135	Continued From page 2	I 135		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to hold evacuation drills quarterly on all shifts for seven of seven residents residing in the facility. (Clients #1, #2, #3, #4, #5, #6, and #7) The findings include: 1. On June 10, 2009, at approximately 11:30 AM, interview with Qualified Mental Retardation Professional (QMRP) and review of the weekly staffing schedule revealed that there were three designated shifts (6:00 AM-4:00 PM; 4:00 PM-12:00 AM and 12:00 AM - 6:00 AM) seven days a week. There was no evidence that the GHRMP conducted simulated fire drills at least four times (4) a year for each shift from June 2008 to May 2009. Review of the fire drill log book on June 10, 2009, beginning at 11:43 AM, revealed that only two drills had been held during the morning shift (on January 4, 2009, at 9:45 AM and January 5, 2009, at 8 AM). Further review of the fire drills revealed there no drill conducted from June 2008 through August 2008 during the 4 PM to 12 AM shift. Interview with the QMRP acknowledged that the drills were not conducted quarterly on each shift. 2. Also see Federal Deficiency Citation W441	I 135	see W440 W 441	

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 9, 2009 through June 12, 2009. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a resident population of seven males with various disabilities. The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at three day programs, as well as a review of client and administrative records, including incident and investigation reports.	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate an injury of origin for one of four clients included in the sample, Client #4) The finding includes: On June 11, 2009, at 12:01 PM, review of Client #4's nursing assessment dated October 24, 2009 revealed a "Current Health Status' section. Under this section, on September 13, 2008, Client #4 was noted with a bruise on the left shoulder and was transported to the Emergency Room (ER) for further evaluation. The ER discharge report revealed the client was diagnosed with a contusion to the left shoulder. At approximately 12:10 PM, inquiry was made regarding the	W 154		

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 154	Continued From page 1 incident report for this injury. The Qualified Mental Retardation Professional (QMRP) provided the surveyor with the incident report, which documented that Client #4 was discovered with discoloration on his left shoulder. Further interview with the QMRP revealed that Client #4's injury to the left shoulder was investigated. The investigation report dated September 22, 2009, revealed that Client #4 was observed with discoloration on his left upper arm around the shoulder by staff and was taken to the ER for further evaluation. Further review of the investigation recommended the facility to continue to monitor until healed. There was no evidence that the QMRP was asked how the client might have sustained the injury to the left shoulder (when, where, how, etc.). There were no additional interviews indicated in the investigative report. There was no evidence whether the facility had sought to determine the source or nature of the injury.	W 154	Incident Management Coordinator failed to Complete thourough investigation. IMC has been replaced. New IMC will be 7/1/09. Provider will ensure new IMC implements investigations consistent with organizations policy & procedures.	7/1/09
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for five of five clients residing in the facility. (Client #1, #2, #3, #4, #5, #6, and #7)	W 159		

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W 159	Continued From page 2 The findings include: 1. The QMRP failed to ensure that clients were provided opportunities for making choices as a part of their self-management. [See W247] 2. The QMRP failed to ensure that fire evaluation drills were conducted quarterly on all shifts. [See W440] 3. The QMRP failed to ensure fire drills were conducted under varied conditions.[See W441] 4. The QMRP failed to ensure staff demonstrated competency in the implementation of the behavior support plans. [See W193] 5. The QMRP failed to ensure the facility furnished and maintained in good repair, a padded pediatric chest strap for Client #2. [See W436]	W 159	See W247 See W440 See W441 See W193 See W436	
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record verification, the facility staff failed to demonstrate competency in the implementation of the behavior support plans (BSPs), for one of the four clients in the sample. (Clients #1) The findings include: 1. The facility failed to ensure staff implemented Client #1's BSP as evidenced below:	W 193		

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W 193	Continued From page 3 During observation on June 9, 2009, at 5:20 PM, Client #1 stopped looking at his magazine and began to stare at the surveyor. The House Manager (HM) asked Client #1 to say hello. The client did not respond and continued to stare. Therefore, the surveyor said hello. At 5:26 PM, Client #1 grabbed the surveyor's shirt and was asked to stop, but the client refused. The HM then removed each finger one by one from the surveyor's shirt until he released his grip. On June 10, 2009, at approximately 2:00 PM, review of the BSP dated October 1, 2008, revealed that "being approached by unfamiliar people or staff is an antecedent to problem behaviors." There was no evidence that the HM (who was acting as the 1:1 staff) made the surveyor aware of Client #1's behavior of grabbing unfamiliar people. 2. On June 9, 2009 at 6:13 PM, Client #1 was observed to snatch his house mate's spaghetti. At 6:16 PM, the House Manager (HM) attempted to redirect Client #1 from snatching food again. As a result, Client #1 grabbed the HM's face. Further observations revealed Client #1 attempted to snatch the other clients food throughout the entire dinner meal. On June 10, 2009, at 11:50 AM, observations at the day program revealed Client #1's 1:1 staff left the classroom without the client. Client #1 was observed without his 1:1 staff for two minutes. At 12:00 PM, during lunch time, the 1:1 staff was observed to leave Client #1 in the cafeteria as he walked into another room.	W 193	QMRP will conduct an in-service on client #1 behavior Support plan and responsibility and role of his 1:1 staff. DAY Program will also conduct an in-service on client #1's behavior support plan	7/10/09 7/10/09

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W 193	Continued From page 4 On June 10, 2009, at 3:00 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #1's 1:1 staff should be within arms length of at all times. Review of BSP confirmed that the Client #1's 1:1 should remain within arms length at all times. There was no evidence that staff demonstrated competency in the implementation of the client's BSP.	W 193		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients were provided opportunities for making choices as a part of their self-management, for one of four clients included in the sample. (Client #2) The finding includes: On June 9, 2009, at 6:16 PM, Client #2 was observed eating a pureed dinner with total assistance. At 6:33 PM, Client #2 drank Pedialyte from a spout while the staff held the cup for him. Review of the Occupational Therapy Assessment dated August 27, 2007, on June 12 2009, at 10:00 AM, revealed Client #2 "is able to hold his cup with minimum assistance from staff. Interview with the Registered Nurse and the Qualified Mental Retardation Professional confirmed that Client #2 is able to hold his cup with minimum assistance. At the time of the survey, the facility's staff failed	W 247	QMRP will schedule an in-service on client #2's meal time protocol.	7/10/09

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W 247	Continued From page 5 to allow Client #1 to exercise his independence with drinking from his spout cup.	W 247		
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility consistently participated on this committee for three of four clients included in the sample. (Clients #1, #3, and #4) The findings include: On June 9, 2009, at 4:57 PM, interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference, revealed that Clients #1, #3, and #4 received psychotropic medications for their maladaptive behavior. 1. On June 9, 2009, at 6:06 PM, Client #1 was observed to use a plate guard during dinner time to help decrease food spillage. At 7:02 PM, Client #1 was observed to received Haldol oral solution 5 mg, Valproic Acid 5 ml, and Metoclopramide HCL 10 ml by mouth during the	W 261	The HRC sign-In sheet comprises of two pages. It was an oversight by the facility to not make copies of the second page from the master HRC folder for the months 6/4/08, 11/10/08, 12/10/08, 1/14/09 and 2/11/09. Please find attached copies of the first and second page of the HRC meeting sign in sheet for the aforementioned months	7/7/09

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W 261	Continued From page 6 medication administration pass. Interview with the Trained Medication Employee (TME) revealed that these medications were prescribed for maladaptive behaviors. Review of the Human Rights Committee (HRC) meeting minutes was conducted on June 11, 2008 at 3:46 PM. According to the HRC minutes dated 5/20/09, 2/11/09, and 11/10/08, Client #1's psychotropic medications and Behavior Support Plan (BSP), diet, hospital bed, and plate guard were reviewed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility was present. This was acknowledged through interview with the QMRP. 2. On June 9, 2009, at 7:11 PM, Client #3 was observed to received Tegretol 400 mg, Luvox 50 mg, abilify 10 mg, and Zyprexa 5 mg by mouth during the medication administration pass. Interview with the Trained Medication Employee (TME) revealed that these medications were prescribed for maladaptive behaviors. Review of the Human Rights Committee (HRC) meeting minutes was conducted on June 11, 2008 at 3:17 PM. According to the HRC minutes dated 5/20/09 and 2/11/09, Client #3's psychotropic medications and Behavior Support Plan (BSP) and diet were reviewed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility was present. This was acknowledged through interview with the QMRP. 3. On June 9, 2009, at 7:25 PM, Client #4 was	W 261		

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W 261	Continued From page 7 observed to received Luvox 50 mg, Risperdal 1 mg, and Depakene 10 ml by mouth during the medication administration pass. Interview with the Trained Medication Employee (TME) revealed that these medications were prescribed for maladaptive behaviors. Review of the Human Rights Committee (HRC) meeting minutes was conducted on June 11, 2008 at 3:26 PM. According to the HRC minutes dated 5/20/09, 2/11/09, and 12/10/08, Client #3's psychotropic medications and Behavior Support Plan (BSP) and diet were reviewed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility was present. This was acknowledged through interview with the QMRP.	W 261		
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to provide routine laboratory testing as determined necessary by the physician, for one of four clients included in the sample. (Client #2) The finding includes: The facility failed to obtain laboratory studies as ordered by the Primary Care Physician (PCP). Review of Client #2's physician's order (PO) from	W 325	RN and LPN will review all clients Physician order sheet to identify labs due for the month.	6/26/09

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W 325	Continued From page 8 October 2008 to May 2009 on June 11, 2009, at approximately 2:10 PM, revealed an order for the client to have laboratory studies for CBC and CMP every two months. There was no evidence of laboratory studies for the Client's CBC and CMP for December 2008. Interview with the Registered Nurse (RN) on June 12, 2009, at approximately 2:30 PM, confirmed that the laboratory studies were not completed as ordered.	W 325		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to furnish and maintain in good repair, a padded pediatric chest strap for one of the four clients included in the sample. (Client #2) The finding includes: Review of Client #2's medical record on June 11, 2009, at approximately 2:00 PM, revealed a diagnosis that included Cerebral Palsy. Further medical records review revealed a Physical Therapy (PT) 3rd quarterly report dated July 28, 2009. According to the PT 3rd quarterly report, a recommendation was made to install a padded pediatric size chest strap to Client #2's new wheel	W 436	The surveyor was shown monthly adaptive equipment audit sheet which documents attempts made by the facility inquiring about client#2's new pediatric strap (at least twice monthly). The facility will continue to work on getting all adaptive equipment in a timely manner and will document all efforts made	7/1/09

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	09G112	A. BUILDING _____ B. WING _____	06/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 02	1228 LAWRENCE STREET, NE WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 9 chair to be used for transportation only. Review of the physical therapy evaluation dated October 30, 2008 stated that the "Qualified Mental Retardation Professional (QMRP) should follow up on the chest strap to be used during transportation for added safety." Review of the 719 form dated August 12, 2008, indicated an order to install a padded pediatric size chest strap. Further review revealed a repeated 719 form dated January 4, 2009. Review of the physical therapy 1st quarterly report dated January 22, 2009 revealed another recommendation for Client #2's pediatric chest strap. Review of the sales service invoice dated April 13, 2009, confirmed delivery of Client #2 Chest strap. Interview with the QMPR on June 12, 2009, at approximately 2:45 PM, indicated that the client did not receive his chest strap in a timely manner due to delay in payment. At the time of the survey, there was no evidence that Client #2 received his chest strap for added safety in a timely manner.	W 436		
W 440	483.470(l)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts for seven of seven clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, and #7)	W 440	QMRP and House Manager will ensure that fire drills are conducted quarterly for each shift. Attached is a copy of the Fire Drill Schedule that will be utilized by the facility	6/26/09

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WHOLISTIC 02	1226 LAWRENCE STREET, NE WASHINGTON, DC 20017

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W 440	Continued From page 10 The finding includes: On June 10, 2009, at approximately 11:30 AM, interview with Qualified Mental Retardation Professional (QMRP) and review of the weekly staffing schedule, revealed that there were three designated shifts (8:00 AM-4:00 PM; 4:00 PM-12:00 AM and 12:00 AM - 8:00 AM) seven days a week. There was no evidence that the facility conducted simulated fire drills at least four times (4) a year for each shift from June 2008 to May 2009. Review of the fire drill log book on June 10, 2009, beginning at 11:43 AM, revealed that only two drills had been held during the morning shift (on January 4, 2009, at 9:45 AM and January 5, 2009, at 8 AM). Further review of the fire drills revealed there no drills were conducted from June 2008 through August 2008 during the 4 PM to 12 AM shift. Interview with the QMRP acknowledged that the drills were not conducted quarterly on each shift.	W 440		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to use different escape routes during fire drills for seven of seven clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, and #7) The finding includes: On June 10, 2009 at beginning at 11:43 AM,	W 441	Provider ~~does~~ disagrees with this deficiency. Varied Conditions were used as stated in the findings. The standard stated is incorrect as the facility did in fact use different escape routes during the fire drills. Using	

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W 441	Continued From page 11 review of the facility's fire drill record revealed that most of the fire drills were conducted via the back, front, side door, and the second level fire escape. On June 12, 2009, observations of the environmental walk-thru and interview with the House Manager revealed there were five (5) methods of egresses. Further review of the fire drill records revealed that the exit to basement had not been used at any time. Interview with the House Manager (HM) revealed that clients use the basement almost daily for exercising on their treadmills. The HM acknowledged that the basement was not used as an escape route during fire drill evacuations.	W 441	four out of five methods of egress is varied and [redacted] meets the standards delineated in the regulations.	6/9/09
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure that each staff prepared food in sanitary conditions at all times for seven of seven clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, and #7) The finding includes: On June 10, 2009, at 3:14 PM, a pack of chicken was observed thawing out inside the kitchen sink with warm water running over it. The Qualified Mental Retardation Professional (QMRP) was made aware this issue an immediately turned the water from warm to cold while the chicken continued to be thawed out inside the sink. The QMRP acknowledged that staff should run cold water over the chicken. There was no evidence that the facility maintained a sanitary environment	W 454	Staff will be in-serviced on time and temperature control as well as acceptable methods of thawing food. Please find attached an outline of the in-service	7/1/09

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W 454	Continued From page 12 to avoid sources and transmission of infection.	W 454		